NH MEDICAL CONTROL BOARD

Richard M. Flynn Fire Academy
222 Sheep Davis Road
Concord, NH

MINUTES OF MEETING

July 21, 2005

Members Present: Donavon Albertson, MD; Tom D'Aprix, MD, Frank Hubbell, DO; Patrick Lanzetta, MD; Jim Martin, MD; Joseph Mastromarino, MD; Douglas McVicar, MD; Sue Prentiss, Bureau Chief; Joseph Sabato, MD; John Sutton, MD; Norman Yanofsky, MD

Members Absent: Chris Fore, MD; Jeff Johnson, MD; William Siegart, DO;

Guests: Dave Dubey, Jonathan Dubey, Janet Houston, Stephanie Dornsife, Jeanne Erickson, Steve Erickson, William Donavan, Donald E. Johnson, Donna York Clark, Fred A. Heinrich

Bureau Staff: Vicki Blanchard, ALS Coordinator, Liza Burrill, Cindy Castagnino, Secretary II, Michelle Duchesne, Program Specialist, Education Coordinator; Kathy Doolan, Field Services Coordinator; Clay Odell, Trauma Coordinator.

I. CALL TO ORDER

Item 1. McVicar called the meeting of the NH Medical Control Board (MCB) to order by on July 21, 2005 at the Dartmouth Hitchcock Medical Center (DHMC) in Lebanon, NH.

Yanofsky, of DHMC, welcomed all to the medical center's new emergency department and encouraged all to stay for a tour following the meeting during the lunch break.

II. ACCEPTANCE OF MINUTES

Item 1. May 19, 2005 Minutes were approved on May 24, 2005, via the email/electronic procedure established in March 2005.

III. DISCUSSION AND ACTION PROJECTS

Item 1. Legislative update - HB257 and SB88: Prentiss reported that HB257 was signed by the governor July 11, 2005. This bill will become effective January 1, 2006 and will require updating administrative rules including prerequisites.

McVicar moved, "thank-you letters be sent to the bill's sponsors and a special note of appreciation to Rep Steve L'Heureux, for their help with HB 257." Albertson 2nd. Vote: Unanimous.

McVicar commented that during the planning process he was surprised to have heard so little opposition to statewide protocols, but still felt concern that people may become more attentive now that the law has passed, so that MCB members and Bureau staff may now begin to hear belated complaints. McVicar urged the board members to educate their peers around the state as to how the new system will work, and its advantages. He stated he thinks it will be very useful to hold our much-discussed joint meeting with ACEP.

Yanofsky expressed some concerns because without local option he will have difficulty producing a single set of protocols that will work for both Vermont and New Hampshire.

SB88 was signed by the governor on June 21, 2005. Prentiss reminded all that this bill reflected a change in rule, which would give an exemption to emergency physicians, nurses, and physician assistants. This exemption would allow these emergency physicians, nurses and physician assistants to take the role of the second ambulance attendant in the event that a critical access hospital was unable to get a fully staffed ambulance for an emergency transfer within thirty (30) minutes. Prentiss reported that she and bureau staff have drafted an interim set of rules which reflected the requirements necessary for exemption. Part of the requirements of the exemption would include a training module, which Jackie Stocking has developed. This training module will be put out for review among interested groups next week. Prentiss will be presenting this draft to the Coordinating Board this afternoon for approval.

Item 2: Prerequisites: Albertson and Blanchard reported that the prerequisite subcommittee met on June 21, 2005 and July 8, 2005. They presented their work in the form of two Tables. Table one shows prerequisites for high-risk, low volume airway skills. Table Two is a matrix that includes procedures allowed by protocol at the First Responder, EMT-B, EMT-I and EMT-P level. Within this matrix skills are marked as:

- Skill allowed under protocol and taught in the Department of Transportation (DOT) curriculum, and
- Skill allowed under protocol after completion of enhanced training module. (see attached)

A. At this time Albertson directed the attention of the Board to Table One "Procedures with Prerequisites". He then presented the following question from the subcommittee.

1. What is the appropriate number of intubations per year for paramedics seeking eligibility for an RSI program? The committee recommended 10 successful live intubations in the prior year, with 5 of these allowed to be manikin intubations.

This spurred much discussion of intubation education reflecting differing philosophies and practices. There are concerns that many medics will have less than 10 field intubations per year, yet their medical resource hospitals may not be willing and able to provide ten tubes in one year. But others felt if the provider or service really wanted the skill and had the support of their medical resource hospital it would not be impossible.

Further discussion included the difference in risk and acceptable error between intubating a code victim versus taking away ability to breath and to protect the airway of a spontaneously breathing patient.

Given the difficulty of the decision, and the timetable we have at hand, the group decided to postpone a decision on this issue until the September 2005 meeting, and to request further investigation be done in the meantime, including a poll of Medical Resource Hospitals with current RSI programs, such as Frisbee, Concord, Derry and DHART.

2. The next question involves page one of the Protocol Subcommittee report dated June 24 - July 8, 2005, fourth (4th) paragraph: referencing PALS. This paragraph states “Children fitting on a Broslow Tape will be managed by Paramedics vis-à-vis the techniques in Protocol 5.0 within which context PALS is recommended.” The question is whether PALS should be required (or recommended).

   Houston explained that this topic came up after discussion of the fact that paramedics are required to maintain their ACLS but not PALS. Houston and Prentiss surveyed the other states to determine who was or was not requiring PALS and discovered that of those responding to the survey, only 13 of 33 required PALS.

   The question was raised, does passing a PALS course mean you have proficiency for a particular skill in the field?

   Yanofsky pointed out that paramedics go through an education program which prepares them for pediatric intubation. He did not feel that it was necessary for the board to require the paramedics to take a certain additional program to prove that proficiency. He reminded the group that ACEP policy is that ABEM board certification covers the entire specialty so there is no need for board-certified emergency physicians to seek “merit badge” credentialing in particular areas.

   McVicar said that he sees an important job of EMS leadership as keeping the system in balance and headed towards the overall goal of better care for everyone. Although specialists and advocates representing certain groups of patients -- such as children, trauma victims, cardiac patients, the elderly, food allergy sufferers, victims of terrorism and so forth – have much to contribute and must have their concerns addressed in the overall spectrum of services EMS provides, nevertheless it is our responsibility to keep a close eye on

the limited resources of time and money available and avoid letting the system get out of balance.

Blanchard and Burrill noted that part of the paramedic biannual refresher included an 8 hour mandatory pediatric component and an 8 hour flexible pediatric component. Under the 8 hour flex component we could require a pediatric airway proficiency module that covers the essential material on airway management in the PALS course.

It was agreed to not require PALS but to further investigate incorporating a pediatric airway curriculum into the eight- (8) hours of flexible pediatric refresher time. This curriculum could be drawn from standards such as PALS, APLS and DOT Paramedic.

B. Members of the Board raised other questions, as follows.

1. Does the board support RSI in children? Board members who commented on this all expressed concerns about safety. The board voted unanimously that RSI would not be used in children.

2. Advanced Airway Course plus CPAP: There were questions as to why CPAP was necessary as part of an RSI program. Albertson explained that if you have been trained to use CPAP and have been using it, it becomes part of your skill set to consider CPAP as an alternative to intubation. Yanofsky commented that he would estimate that CPAP saves approximately 50% of patients from intubation.

3. Yanofsky asked what the term "experienced airway provider" meant in Table One under “Patient Milieu.” Albertson explained that the subcommittee used that vague term intentionally to allow flexibility in deciding what person is adequately trained to assist a paramedic. Yanofsky felt the description was vague. Members of the board felt that the whole point of standard prerequisites was to avoid confusion and unequal standards of care. Yanofsky offered the language, "EMT-Intermediate with DOT Module 8." The board approved the language change.

C. Equipment list. Blanchard stated that MAST was part of the EMT-Basic curriculum and still taught, but was no longer in any of the NH Patient Care Protocols. She asked if the board would consider removing it from the state's mandatory ambulance equipment list. The board voted unanimously to recommend removal of MAST trousers from the mandatory ambulance equipment list

D. McVicar asked if there were any other items on the mandatory equipment list that needed to be removed. Jonathan Dubey asked if the requirement for saline could be less restrictive. Currently the mandatory list requires 2 liters of saline for irrigation in the form of bottles. The saline in an IV bag does not count. Several providers reported that they felt this was illogical. The board

voted unanimously to recommend that the term "saline in bottles" be changed to "saline for irrigation" with the intention that a service may keep IV bags of saline for irrigation, and not be required to keep bottles.

E. Blanchard presented “Table 2: Procedure Grid by Provider”. She explained the matrix and pointed out certain highlighted items for special attention.

    1. Albertson asked the board what they thought about transfers. Is this an expanded scope of practice topic? Critical Care Transport?

    2. Sutton stated that he liked the idea of a transfer module.

    3. Prentiss spoke of the Critical Care Transport Paramedic course offered by the University of,Maryland as well as the belief that Vermont had developed a program or protocol on this topic. Prentiss felt that before any decisions are made on this topic, a much bigger discussion after further investigation would be appropriate. The board agreed.

F. It was agreed that Blanchard would summarize the above discussions for distribution. After allowance for consideration and investigation we will be in a better position to make final decisions on the various topics.

Item 3: Tactical Paramedic programs. Bill Donovan, paramedic, former officer NH State Police, presented the MCB with a proposal for a NH Tactical Paramedic Team. The team would have 20 people trained in tactical Paramedicine and could include additional skills not covered currently in the NH Patient Care Protocols such as emergency dental care, extended operations, and veterinary medicine. Donovan illustrated his point with various examples of situations in the past, both here in NH and elsewhere, where such a program would have been beneficial. Donovan felt that to make this happen he would need the MCB support and approval.

Hubbell noted that a training program he developed covers much of what Donovan needs. The program has been taught many times, and is very well received. Hubbell extended an invitation to Donovan to contact him to speak further on the topic.

McVicar thanked Donovan for his presentation. McVicar stated that he felt that 99% of the procedures that Donovan’s group would use are covered under current NH Statewide Protocols. McVicar stated that he isn’t sure the MCB has much to contribute to Donovan's initial priorities of funding, pulling a group together, finding a medical resource hospital and seeking cooperation with existing teams, but feels that Donovan’s ideas are very interesting and that the MCB would like to be kept informed of his progress.

Item 4: Training Gaps: Prentiss and Blanchard presented the group with a handout illustrating a licensing and training concept for Basic, Intermediate and Paramedic. (see attached) With the passage of HB257 and the end of local option protocols, certain skills and procedures that are not taught in the DOT curricula, and that were formerly covered by local option will be now be allowed

under standing order. The handout outlined procedures needing additional training modules to ensure all NH Licensed Providers are trained in all skills and procedures allowed at the applicable level of licensure.

The Board approved the concept and will offer any assistance requested as the rules drafting process continues.

Item 5: Board of Pharmacy. McVicar and Blanchard attended the Board of Pharmacy meeting on July 20, 2005 and reported the following:

1. granisetron (Kytril) and dolasetron (Anzemet) were both approved for addition to the Approved Medication List for EMS providers.

2. The Board of Pharmacy is willing to consider any classes of drugs that we submit for approval. However there were several issues raised by the Board of Pharmacy about the concept of approving classes rather than individual agents. For example, some classes such as "pressors" and "cephalosporins" include agents with significant differences in pharmacokinetics, activity, toxicity, economics and mode of use. Also, once a class is approved, how do we deal with new agents that appear in the future as members of that class. Are we pre-approving medicines before we have any way to know about them? Also, the Board of Pharmacy has no problem with considering for approval multiple medications individually; there would be no administrative advantage for the boards in approving agents grouped as a class.

IV. INCUBATING PROJECTS & SUBCOMMITTEE REPORTS

ACEP: No report.

Bureau and Division Update: Director Mason is absent today as he is involved in a Homeland Security Grant Reviews. Prentiss presented her Bureau report. (see attached). Further, Prentiss explained that grant money was just received for a mentoring program, where experienced paramedics will be sent to rural areas with new paramedics and will mentor them. Please look for more information in the near future.

Intersections Project: : Dr. Sabato was not present for most of the MCB meeting but did arrive in time to report the following: The Intersection Project will be hosting the Safe Driver Summit on September 15, 2005 with the theme, "Responder Safety." Derry's Fire Chief and Steve Achilles will be among the speakers. Sabato will email further information.

NH Bureau of Emergency Communications: No report.

NH Trauma System: Dr. Sutton reported:

The Hospital designation process is approximately a third completed. Three hospitals have finished their re-reviews. Cottage and Monadnock have expressed interest in joining the review process.

Trauma Conference: Prentiss mentioned in her report and Sutton added that in the past the conference was funded with grant money which is not available this year and the Bureau has agreed to pickup the cost of this valuable conference. The Trauma Conference for this year is currently scheduled for November 17th. It was pointed out that this is, most unfortunately, the same day as the Medical Control Board and Coordinating Board Meetings.

Triage Protocol: Air Transport: Clay Odell has organized a group to review air transports data from EMS scenes in NH to see if they meet what is currently in the protocol guidelines.

Odell further reported that in March an Interfacility Summit was held which generated interest and a working group. This committee has narrowed down the summit priorities and made a work plan:

1. Eliminate decision making based on ability to pay.
2. Generic decision tree to match patient needs to ambulance availability.
3. Explore mechanism for crew sharing.

TEMSIS: Michelle Duschesne reported, see attached.

Other Business: Dr. Albertson asked if diversions were a statewide problem? He expressed chagrin that hospitals have been functioning under maximum capacity for more then five years, yet not building new capacity. Where does this leave us in the event of an MCI, where is our surge capacity?

Sabato commented that it was a growing concern throughout the state and a Diversion Task Force was formed in April.

Yanofsky stated hospitals could not afford empty beds. In a disaster an effective procedure may be to evacuate stable patients from their beds/rooms to make space for more acute incoming patients.

McVicar: In the “daily crisis”, non-MCI, situation communication as to who has beds is also an issue. It should not be the responsibility of ambulance services to try to ferret out beds for their patients. The NEARS group is working on multiagency communication systems that may allow such information to be updated continuously. A member noted that the WEB-EOC is an example for implementation in NH.

Albertson hoped that the MCB could be a voice for reform. He felt hospitals were penalized for trying to expand. Money is available, but if it is used for expansion, insurance companies will respond by decreasing their rate of payment.

Kathy Doolan said that during last May's MCB meeting, which was held during EMS Week, it was the intent of the Bureau to present each member with a silk screen gym bag as a token of appreciation for the work they do. Because the bags were not received until after the meeting date, she has them with her today and asked if members would see her following the meeting.

Dr. Yanofsky invited all to tour the emergency department and DHART hanger during the lunch break, and also check out the smart Annie code simulations teaching lab.

V. ADJOURNMENT

Motion by Yanofsky, seconded by Albertson to adjourn. Approved. Meeting adjourned at 12:00.

VI. NEXT MEETING

September 15, 2005. Place to be announced.

Respectfully Submitted,

Suzanne M. Prentiss, Bureau Chief, EMS

(Prepared by Vicki Blanchard, ALS Coordinator)